

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

41528

1. PLACE OF DEATH

Comp. New Madrid Registration District No. 820 File No. 111
 Township East Primary Registration District No. 670-580 Registered No. _____
 City Beaumont St. _____ Ward _____

2. FULL NAME

John William Millar
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 11 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5-7 | 10 | 16 | —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mass Prairie
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER John W Millar

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Ruth Scott

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
 (STATE OR COUNTRY) Mo

14. INFORMANT Blauche Millar
 (Address) Beaumont Mo

15. FILED 10/30 W. Edkins
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 27 19 29

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 19 29 to Dec 27 19 29 that I last saw h. live on Dec 27 19 29, and that death occurred, on the date stated above, at 1:00 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
gpa (duration) yrs. mos. ds. 1 — —

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. ds. — — —

18. WHERE WAS DISEASE CONTRACTED None
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH. no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam

(Signed) Howard M. Kenley, M. D.

12/28, 1929 (Address) Beaumont Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Dogwood DATE OF BURIAL 12/29 19 29

20. UNDERTAKER H. Welch ADDRESS Beaumont Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. MEANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important.

191 JAN 12 1930

Kenley

100

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100

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH:

County New Madrid Registration District No. 821 File No. _____
 Township East Primary Registration District No. 3801 Registered No. 11
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

John William Miller
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
	If LESS than 1 day, _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
10. NAME OF FATHER		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) _____ 19____

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ since on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) _____, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

PARENTS

14. INFORMANT (Address) _____

15. FILED 10/30/30 REGISTRAR

SUPPLEMENTARY

N. b.—Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.—Exact statement of CAUSE OF DEATH is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

8-25-19-8